

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02166

## 2171 CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>md.</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
40 <u>Easton, Md.</u>		16 days		80 <u>Federalburg</u> 058-2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
80 <u>Easton Memorial Hospital</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Albert C. Andrew</u>				<u>2 15 1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>white</u>	<u>MARRIED</u>	<u>May 19, 1884</u>	<u>71</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Carpenter</u>		<u>Carpenter</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Martin Luther Andrew</u>				<u>Martha Adams</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>no</u>		<u>218-05-2554</u>		<u>Mrs. Carrie M. Andrew (wife)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
332X IMMEDIATE CAUSE							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) DUE TO							
(B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
<u>2</u>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While at work Not while at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/31</u> 19 <u>56</u> , to <u>2/15</u> 19 <u>56</u> , that I last saw the deceased alive on <u>2/15</u> 19 <u>56</u> , and that death occurred at <u>2:50</u> P. M. from the causes and on the date stated above.							
SIGNATURE		M. D.		ADDRESS		DATE SIGNED	
<u>Edw. H. H. H.</u>		<u>Captain</u>		<u>Captain</u>		<u>17 February 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/18/56</u>		<u>Bethel</u>		<u>Federalburg Md R1</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>2/16/56</u>		<u>H. H. H.</u>		<u>Harvey Williams</u>		<u>Federalburg Md.</u>	

BUREAU V. S.

FEB 23 1956

RECEIVED

1

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 2186 CERTIFICATE OF DEATH

02167

Reg. Dist. No. 290

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Talbot</u>		STATE <u>Maryland</u>		COUNTY <u>Talbot</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (On this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Easton</u>		<u>Life</u>		TOWN <u>Easton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route 2</u>				STREET ADDRESS (if rural give location) <u>Route 2</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Katie S. Blake</u>				<u>2 21 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
<u>Female</u>	<u>Col</u>	<u>married</u>	<u>5/13/06</u>	<u>49</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Factory labor Domestic</u>		<u>Maryland</u>		<u>U.S. A</u>			
13. FATHER'S NAME <u>John H. Skinner</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>29-14-3058</u>		17. INFORMANT & ADDRESS <u>Beamon Blake Canton, Md</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>331X Cerebral hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at..... M., from the causes and on the date stated above.							
SIGNATURE <u>Lewis O. M. D. M.E.</u>				DATE SIGNED <u>2-25-56</u>			
ADDRESS (Street, city, town, state) <u>Easton Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/26/56</u>		<u>New Chapel Cem.</u>		<u>Easton Rta 2 MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>2/23/56</u>		<u>N. H. Neer</u>		<u>James S. Daniel</u>		<u>Easton Md.</u>	

**INSTRUCTIONS:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# CERTIFICATE OF DEATH

REG. NO. 123

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. TIME OF DEATH

6. PLACE OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF DECEASED

13. SIGNATURE OF NEXT OF KIN

14. SIGNATURE OF BURIAL OFFICIAL

15. SIGNATURE OF INTERVIEWER

16. SIGNATURE OF INTERVIEWER

17. SIGNATURE OF INTERVIEWER

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87. SIGNATURE OF INTERVIEWER

BUREAU V. S.

MAR 5 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2187

## CERTIFICATE OF DEATH

Reg. Dist. No.

02168

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lumis Mills (Rural)</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lumis Mills (Rural)</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>00</i>		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) <i>John</i> First <i>Flamer</i> Middle <i>Flamer</i> Last		4. DATE OF DEATH <i>Feb</i> Month <i>27</i> Day <i>1956</i> Year	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 2, 1869</i>
9. AGE (In years last birthday) <i>86</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Talbot</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm Hand</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Alexander Flamer</i>		14. MOTHER'S MAIDEN NAME <i>Charlotte Roberts</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Mary Ethel Mooney</i> Address <i>Lumis Mills</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Left Hemiplegia</i> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized Cerebral Sclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i> <i>yes</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb 22</i> , 19 <i>56</i> , to <i>Feb 27</i> , 19 <i>56</i> ; that I last saw the deceased alive on <i>Feb 26</i> , 19 <i>56</i> , and that death occurred at <i>6:00</i> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W. F. Buell</i>		ADDRESS (Street, city or town, state) <i>19 Jeldness St., Easton, Md.</i> DATE SIGNED <i>3-1-56</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Mar. 2, 1956</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Coppersville Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Lumis Mills Talbot Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>M. E. Purnanston</i> ADDRESS <i>Easton</i>		24. REC'D BY REGISTRAR <i>3/2/56</i> DATE	
		24b. REGISTRAR'S SIGNATURE <i>W. H. Neer</i>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

82124

Reg. No. 1-1-11

<p>1. Name of deceased (Print or write full name)                  _____</p>		<p>2. Sex                  Male <input type="checkbox"/> Female <input type="checkbox"/></p>	
<p>3. Date of birth (Month, day, year)                  _____</p>		<p>4. Place of birth (City, State, Country)                  _____</p>	
<p>5. Date of death (Month, day, year)                  _____</p>		<p>6. Place of death (City, State, Country)                  _____</p>	
<p>7. Cause of death (List all causes, beginning with immediate cause)                  _____                  _____                  _____</p>		<p>8. Manner of death (Check one)                  Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Undetermined <input type="checkbox"/></p>	
<p>9. Signature of attending physician (Print name)                  _____</p>		<p>10. Signature of registrar (Print name)                  _____</p>	
<p>11. Date of registration (Month, day, year)                  _____</p>		<p>12. Office of registration (City, State)                  _____</p>	

BUREAU V. S.

MAR 6 1956

RECEIVED



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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2188 **CERTIFICATE OF DEATH**

02169

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Talbot</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Easton</u>		<u>Life</u>		TOWN <u>Easton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route II</u>				STREET ADDRESS (If rural give location) <u>Route II</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) (Middle) (Last) <u>Sadie E. Flamer</u>				<u>2</u> <u>14</u> <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>Col</u>	<u>Widowed</u>	<u>2/10/72</u>	<u>84</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>House work</u>		<u>Domestic</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>Gustavus Smith</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Ann Tilghman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
						<u>Mrs. Rachel See Easton, Md.</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
430.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arterio Sclerosis</u>				<u>yes</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Diabetes Mellitus</u>				<u>yes</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-1</u> , 19 <u>56</u> , to <u>2-14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-13</u> , 19 <u>56</u> , and that death occurred at <u>5:00</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>W. F. Buell</u>				ADDRESS (Street, city, town, state) <u>Easton, Md.</u>		DATE SIGNED <u>2-18-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/18/56</u>		<u>Chappel Cem.</u>		<u>Easton Rt 2, MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>FEB 27 1956</u>		<u>N. J. Harris</u>		<u>James B. Darrell</u>		<u>Easton, Md.</u>	

# DEATH CERTIFICATE

MASS. LAND STATE DEPARTMENT OF HEALTH - BUREAU V. S.

1. Name of deceased (Print or write full name)

2. Sex

3. Age

4. Date of birth

5. Place of birth

6. Date of death

7. Place of death

8. Cause of death

9. Manner of death

10. Signature of physician

11. Signature of registrar

12. Signature of informant

13. Signature of witness

14. Signature of funeral director

15. Signature of undertaker

16. Signature of cemetery

17. Signature of burial place

18. Signature of interment

19. Signature of burial

20. Signature of burial

21. Signature of burial

22. Signature of burial

23. Signature of burial

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BUREAU V. S.

1956 27 28

RECEIVED



2189

CERTIFICATE OF DEATH

Reg. Dist. No: 290

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Trappe</b>		c. LENGTH OF STAY IN 1b <b>entire life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>80</b>		d. STREET ADDRESS <b>Trappe</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Katie M. Frampton</b>		4. DATE OF DEATH Month Day Year <b>Feb. 23 19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 22, 1875</b>
9. AGE (In years last birthday) <b>80 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Silas Sullivan</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Helsby</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Bennett Frampton</b>		Address <b>Trappe, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Hepatitis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks -</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis -</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>none</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 2-23 - 1956</b> and that death occurred on <b>Feb 23 - 1956</b> at <b>7:30 A.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <b>2-26-56</b>	
ACTUAL SIGNATURE <b>William L. Winters</b> M.D.		PHYSICIAN'S NAME (Type) <b>WILLIAM L. WINTERS EASTON MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>2-27-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Easton, Talbot, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. E. Newman</b>		24a. REC'D BY REGISTRAR <b>2/28/56</b>	
24b. REGISTRAR'S SIGNATURE <b>M. A. Neekes</b>			

# CERTIFICATE OF DEATH

BUREAU V. S.

MAR 5 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film G191, 2-11-56 et

2172

## CERTIFICATE OF DEATH

03272

Reg. Dist. No.

290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>				c. LENGTH OF STAY IN TB <u>5 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>80 Easton Memorial</u>				d. STREET ADDRESS <u>St. Michaels</u>			
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>Engel</u> Last <u>Engel</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>24</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 20, 1896</u>	
9. AGE (In years last birthday) <u>59</u>		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
13. FATHER'S NAME <u>Fred Engel</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Moskey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>Work War I</u>		17. INFORMANT <u>Edward Wrothen - St Michaels MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X Left Hemiplegia</u> DUE TO (b) <u>Cerebral Hemorrhage</u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>6 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>2-19</u> , 19 <u>56</u> , to <u>2-24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-23</u> , 19 <u>56</u> , and that death occurred at <u>1:40</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Lu F. Buechel</u>				ADDRESS (Street, city or town, state) <u>19400 St Michaels Rd</u>			
PHYSICIAN'S NAME (Type) <u>St. Michaels</u>				DATE SIGNED <u>2-27-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 27, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Michaels Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>St Michaels MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>St. Michaels</u>				ADDRESS <u>St Michaels</u>			
24a. REC'D BY REGISTRAR <u>2/27/56</u>				24b. REGISTRAR'S SIGNATURE <u>M. H. Neuman</u>			





RECEIVED

FEB 17 1956

BUREAU V. S.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02172

## 2174 CERTIFICATE OF DEATH

Reg. Dist. No. 290...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>TALBOT</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>TALBOT</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Easton</u>		LENGTH OF STAY (in this place) <u>10</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>RURAL - LAAGWOODS</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>"WYE HEIGHTS"</u>				STREET ADDRESS (If rural give location) <u>"WYE HEIGHTS"</u>			
3. NAME OF DECEASED: (First) <u>WALTER</u> (Middle) <u>CHARLES-VINSON</u> (Last) <u>GRUBB</u>				4. DATE OF DEATH: (Month) <u>2</u> (Day) <u>3</u> (Year) <u>1956</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH: <u>MAY 23, 1905</u>	9. AGE last birthday <u>50</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>LABORER</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>FARMING</u>		11. BIRTHPLACE (State or foreign country): <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>FRANK GRUBB</u>				14. MOTHER'S MAIDEN NAME: <u>ELIZABETH SWEENEY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY No. <u>218-16-7149</u>		17. INFORMANT & ADDRESS: <u>KATHARINE M. GRUBB, EASTON, R.D., MD</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>420.1</u> (A) <u>Coronary Occlusion c Myocardial Infarction</u> <u>Hours?</u>							
ANTECEDENT CAUSE (S) (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. _____							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>2-3-</u> 19 <u>56</u> , and that death occurred at <u>7:50 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Donald H. Barkley</u>		ADDRESS <u>Easton, Md.</u>		DATE SIGNED <u>2-3-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>FEB. 7, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>LANDING NECK CEMETERY</u>		LOCATION (City, town, or county) (State) <u>EASTON, R.D., MARYLAND</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2/4/56</u>		REGISTRAR'S SIGNATURE <u>N.A. Newvine</u>		24. FUNERAL DIRECTOR <u>W. Hampton Canoll</u>		ADDRESS <u>EASTON, MD.</u>	

RECEIVED

FEB 9 1956

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2175

## CERTIFICATE OF DEATH

Reg. Dist. No.

02173

290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sherwood</u> X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>80 Memorial Hospital</u>		d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lucy</u> First <u>V. Landon</u> Middle <u>V.</u> Last		4. DATE OF DEATH <u>Feb.</u> Month <u>21</u> Day <u>1956</u> Year	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1, 1896</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John T. Landon</u>		14. MOTHER'S MAIDEN NAME <u>Maving Parks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. J. Herman Landon (brother)</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive cerebral vascular</u> DUE TO (c) <u>cardiac failure - acute</u>			INTERVAL BETWEEN ONSET AND DEATH <u>42 hrs</u> - -
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Aug</u> , 19 <u>53</u> , to <u>2-21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-21</u> , 19 <u>56</u> , and that death occurred at <u>11:45</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Guy M. Reeser Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>St Michael md</u> DATE SIGNED <u>2-24-56</u>	
PHYSICIAN'S NAME (Type) <u>Guy M Reeser Jr</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/23/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sherwood</u>	22d. LOCATION (City, town, or county) (State) <u>Sherwood Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Norman D. Marshall - St. Michael</u> ADDRESS		24a. REC'D BY REGISTRAR <u>2/22/56</u> DATE	24b. REGISTRAR'S SIGNATURE <u>N.H. Reeser</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02174

2190

## CERTIFICATE OF DEATH

Item 9, Film G194 3-23-56 et

Reg. Dist. No. 290

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Talbot</b>		STATE <b>Maryland</b> COUNTY <b>Talbot</b>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		TOWN <b>Easton</b>		TOWN <b>Easton</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Route 2</b>				STREET ADDRESS (If rural give location) <b>Route II</b>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <b>George</b>		(Middle) <b>R.</b>		(Last) <b>Litt Le</b>		<b>2 28 19 56</b>	
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<b>Male</b>	<b>Col</b>	<b>Single</b>	<b>10/17/41</b>	<b>13 1/2 yrs.</b>	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life even if retired) <b>student</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>student</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>
<b>13. FATHER'S NAME</b> <b>James Little</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Viola Brooks</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>—</b> (If Yes, give war or dates of service)			<b>16. SOCIAL SECURITY NO.</b> <b>—</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mr. James Little, Easton, Md.</b>		
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>16. MEDICAL CERTIFICATION</b>	
<b>9121</b> IMMEDIATE CAUSE (A) <b>Broken neck</b>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>			<b>19b. MAJOR FINDINGS OF OPERATION</b>			<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input checked="" type="checkbox"/>			<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b> <b>farm</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b> <b>Talbot Maryland</b>		
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b> <b>3:30 Feb 28 1956 P.M.</b>			<b>21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b> <b>Trapped under over on train</b>		
<b>22. I hereby certify that I attended the deceased from 28 Feb, 1956, to 28 Feb, 1956, that I last saw the deceased alive on 28 Feb, 1956, and that death occurred at 28 Feb, 1956, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>James B. Daskell</b>				<b>ADDRESS</b> (Street, city, town, state) <b>Easton Maryland</b>		<b>DATE SIGNED</b> <b>1 Mar 56</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>3/2/56</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Williamstown</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Easton Md.</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <b>N.A. Neeress</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>James B. Daskell</b>		<b>ADDRESS</b> <b>Easton, Md.</b>	
<b>DATE</b> <b>3/2/56</b>							

SMITHSONIAN INSTITUTION

RECEIVED  
MAR 6 1956  
BUREAU V. S.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 11

1. NAME OF DECEASED James H. H. H.		2. SEX Male		3. AGE 45	
4. DATE OF DEATH March 5, 1956		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. SIGNATURE OF PHYSICIAN J. H. H.	
10. SIGNATURE OF REGISTRAR J. H. H.		11. SIGNATURE OF WITNESSES J. H. H.		12. SIGNATURE OF DECEASED J. H. H.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8, File G1933-1-56 et

2176

CERTIFICATE OF DEATH

Reg. Dist. No.

02175  
210

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>		c. LENGTH OF STAY IN 1b <b>32 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Creamery Lane</b>		d. STREET ADDRESS <b>Creamery Lane</b>	
3. NAME OF DECEASED (Type or print) First <b>Cora</b> Middle <b>D. Marshall</b> Last		4. DATE OF DEATH Month <b>Feb.</b> Day <b>22</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 26, 1872</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dorchester Co.</b>	
13. FATHER'S NAME <b>WILLIAM SHORT</b>		14. MOTHER'S MAIDEN NAME <b>MARY MOANEY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-34-3869</b>	
17. INFORMANT <b>MR. BERNARD MARSHALL - EASTON, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiac Hypertrophy</b> DUE TO (c) <b>Ca of Thyroid</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs</b> <b>yes</b> <b>yes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>generally poor health</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-1</b> , 19 <b>56</b> , to <b>2-22</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>2-22</b> , 19 <b>56</b> , and that death occurred at <b>3 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Martin F. Buell</b>		DATE SIGNED <b>2-23-56</b>	
PHYSICIAN'S NAME (Type) <b>Martin F. Buell</b>		ADDRESS (Street, city or town, state) <b>Easton, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2-25-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>EAST NEW MARKET</b>		22d. LOCATION (City, town, or county) (State) <b>EAST NEW MT. ROCHESTER MARYLAND</b>	
24a. REC'D BY REGISTRAR <b>M. F. Buell</b>		24b. REGISTRAR'S SIGNATURE <b>M. F. Buell</b>	

CERTIFICATE OF DEATH

8112

DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY	
FEB 27 1956		BOSTON		BOSTON		SUFFOLK	
DECEASED'S NAME		SEX		AGE		RACE	
JOHN J. BROWN		MALE		45		WHITE	
MARRIED		OCCUPATION		EDUCATION		RELIGION	
YES		LABORER		8		CATHOLIC	
DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY	
FEB 15 1911		BOSTON		BOSTON		SUFFOLK	
DECEASED'S ADDRESS		CITY		COUNTY		STATE	
1234 MAIN ST.		BOSTON		SUFFOLK		MASS.	
DECEASED'S OCCUPATION		DECEASED'S EDUCATION		DECEASED'S RELIGION		DECEASED'S RACE	
LABORER		8		CATHOLIC		WHITE	
DECEASED'S CAUSE OF DEATH		DECEASED'S MANNER OF DEATH		DECEASED'S PLACE OF DEATH		DECEASED'S CITY	
HEART DISEASE		NATURAL		BOSTON		SUFFOLK	
DECEASED'S SIGNATURE		DECEASED'S ADDRESS		DECEASED'S CITY		DECEASED'S COUNTY	
JOHN J. BROWN		1234 MAIN ST.		BOSTON		SUFFOLK	
DECEASED'S DATE OF BIRTH		DECEASED'S PLACE OF BIRTH		DECEASED'S CITY		DECEASED'S COUNTY	
FEB 15 1911		BOSTON		BOSTON		SUFFOLK	
DECEASED'S OCCUPATION		DECEASED'S EDUCATION		DECEASED'S RELIGION		DECEASED'S RACE	
LABORER		8		CATHOLIC		WHITE	

BUREAU V. S.

FEB 27 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2177

CERTIFICATE OF DEATH

02176

Reg. Dist. No. 290

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>80 Memorial Hospital</u>				d. STREET ADDRESS <u>512 August Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>E</u> Last <u>Mayer</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>27</u> Year <u>1956</u>			
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1, 1888</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
10c. CITIZEN OF WHAT COUNTRY? <u>USA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William E. Gaines</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Dulin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. William E. Mayer, son</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Myocardial Infarct, Recent &amp; Old.</u> DUE TO (b) <u>Coronary occlusion</u> DUE TO (c) <u>Atherosclerosis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>SEPT.</u> , 19 <u>55</u> , to <u>FEB. 27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>FEB. 27</u> , 19 <u>56</u> , and that death occurred at <u>8:00</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Donald A. Bartley</u> M.D.				ADDRESS (Street, city or town, state) <u>9 N. Hanson St. Easton, Md.</u> DATE SIGNED <u>2-27-56</u>			
PHYSICIAN'S NAME (Type) <u>DONALD F. BARTLEY</u> M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Feb 29</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Talbot Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. E. Pearson &amp; Son</u> ADDRESS <u>Easton Md</u>				24a. REC'D BY REGISTRAR <u>2/29/56</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Newsum</u>	

CERTIFICATE OF DEATH

5177

<p>1. NAME OF DECEASED                  [Faint, illegible text]</p>		<p>2. SEX                  [Faint, illegible text]</p>	
<p>3. AGE                  [Faint, illegible text]</p>		<p>4. DATE OF BIRTH                  [Faint, illegible text]</p>	
<p>5. PLACE OF BIRTH                  [Faint, illegible text]</p>		<p>6. OCCUPATION                  [Faint, illegible text]</p>	
<p>7. CAUSE OF DEATH                  [Faint, illegible text]</p>		<p>8. MANNER OF DEATH                  [Faint, illegible text]</p>	
<p>9. DATE OF DEATH                  [Faint, illegible text]</p>		<p>10. PLACE OF DEATH                  [Faint, illegible text]</p>	
<p>11. SIGNATURE OF PHYSICIAN                  [Faint, illegible text]</p>		<p>12. SIGNATURE OF REGISTRAR                  [Faint, illegible text]</p>	
<p>13. SIGNATURE OF WITNESS                  [Faint, illegible text]</p>		<p>14. SIGNATURE OF DECEASED                  [Faint, illegible text]</p>	

BUREAU V. S.

MAR 6 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

2191 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03286  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 13, 14, 23

Reg. Dist. No. 291

1. PLACE OF DEATH o. COUNTY <b>TALBOT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>PENNSYLVANIA</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>outside St. Michaels</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>08</b>		d. STREET ADDRESS <b>WARREN</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Louis Charles Niederlander Jr.</b>		4. DATE OF DEATH Month Day Year <b>Feb. 21 1956</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-12-30</b>
9. AGE (In years last birthday) <b>25 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>pilot</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>	
11. BIRTHPLACE (State or foreign country) <b>Cleveland Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Louis Charles Niederlander</b>		14. MOTHER'S MAIDEN NAME <b>Ione Folkman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Jet Airplane Crash</b> <b>860X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>plane crashed in creek</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>12 2-21 19 56</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Broad Ck</b>		20f. (City or town) (County) (State) <b>near St. Michaels Talbot Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Louis S. Welty</b> EXAMINER'S NAME (Type) <b>Louis S. Welty, M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <b>12-21-56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		22b. DATE THEREOF <b>2-21&amp;22-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>to Naval Air Sta. Chincoteague, Va.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Templeton Funeral Home, Warren, Pa.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>DATE 3/2/56</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. Robert P. Self</b>	



STATE OF KENTUCKY  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		CITY OF BIRTH		CITY OF DEATH		COUNTY OF BIRTH		COUNTY OF DEATH		STATE OF BIRTH		STATE OF DEATH	
JAMES H. HARRIS		45		M		W		M		M		H		H		H		H		H		H		H		H		H	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		POSTMORTEM		AUTOPSY		HISTORICAL		FAMILY HISTORY		SOCIAL HISTORY		HABITS		DIET		EXERCISE	
JAN 10 1956		HOME		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		PAIN IN CHEST		NO		NO		NO		NO		NO		NO		NO		NO		NO	
SIGNATURE OF EXAMINER		DATE		PLACE		CITY		COUNTY		STATE		FEDERAL BUREAU OF INVESTIGATION		U.S. DEPARTMENT OF JUSTICE		WASHINGTON, D.C.		RECEIVED		JAN 10 1956		BUREAU V. S.		JAN 10 1956		JAN 10 1956		JAN 10 1956	

BUREAU V. S.

JAN 10 1956

RECEIVED



## 2178 CERTIFICATE OF DEATH

Reg. Dist. No. 290...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Talbot</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Talbot</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
40 <i>Easton, Maryland</i>		23 hrs.		40 <i>Easton -</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
80 <i>Memorial Hospital - Easton</i>				40 <i>Glenwood Ave.</i>			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year) OF DEATH:			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<i>Clara</i>				<i>Rose</i>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<i>Female</i>		<i>Black</i>		<i>Single</i>		<i>May 3, 1890</i>	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
65 yrs.		Months Days		Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<i>House work</i>				<i>H.W.</i>		<i>Delaware</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>William A. Cannon</i>				<i>Sara Horner</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
						<i>Avis E. Johnson (Daughter)</i>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X							
IMMEDIATE CAUSE							
(A) <i>Hypertensive Heart Disease</i>							
DUE TO							
ANTECEDENT CAUSE (B)							
<i>Hypertension</i>							
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<i>Generalized arteriosclerosis</i>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
0 <i>none</i>				<i>none</i>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
<i>no</i>				<i>no</i>		<i>no</i>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
<i>no</i>				<i>no</i>		<i>no</i>	
22. I hereby certify that I attended the deceased from <i>April 1955</i> , to <i>2-15-1956</i> , that I last saw the deceased alive on <i>2/15</i> , 1956, and that death occurred at <i>8:55</i> A.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
<i>William S. Winter</i>				<i>Easton</i>		<i>7/16/56</i>	
23. BURIAL, CREMATION, REMOVAL (Specify)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<i>Burial</i>				<i>2/18/56</i>		<i>Bridgeville</i>	
DATE REC'D BY LOCAL REGISTRAR				REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
<i>2/16/56</i>				<i>H. H. Reeves</i>		<i>James B. Boshell, Easton, Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 23 1956

BUREAU V. S.

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02178

2179 **CERTIFICATE OF DEATH**

Item 2, Film 192 2-16-56 et

Reg. Dist. No. 290

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>40 Easton</u>		LENGTH OF STAY (In this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		<u>40</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>100</u>				STREET ADDRESS (If rural give location) <u>406 August St.</u>		<u>1</u>	
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Milton</u> (First) <u>C</u> (Middle) <u>Saulsbury</u> (Last)				<b>4. DATE OF DEATH</b> (Month) <u>Feb.</u> (Day) <u>7</u> (Year) <u>1956</u>			
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W.</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Single</u>	<b>8. DATE OF BIRTH</b> <u>Aug 16, 1890</u>		<b>9. AGE last birthday</b> <u>65</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Clerical</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Hospital</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Talbot County, Md</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>	
<b>13. FATHER'S NAME</b> <u>John J. Saulsbury</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Josephine Burrage</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>World War #1</u>		<b>16. SOCIAL SECURITY NO.</b> <u>216-03-7538</u>		<b>17. INFORMANT &amp; ADDRESS</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>151X IMMEDIATE CAUSE</b> (A) <u>CARCINOMA of STOMACH</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>6 mos.</u>	
<b>ANTECEDENT CAUSE(S)</b> (B) <u>DUE TO</u>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b> (C) <u>DUE TO</u>							
<b>STATING UNDERLYING CAUSE LAST.</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u>SEPT. 6, 1955</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <u>CARCINOMA of STOMACH</u>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>Sept. 7, 1955</u> , <b>to</b> <u>Feb. 7, 1956</u> , <b>that I last saw the deceased alive on</b> <u>Feb. 7, 1956</u> , <b>and that death occurred at</b> <u>4:25 P.M.</u> , <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Donald H. Bartley</u>				<b>ADDRESS</b> (Street, city, town, state) <u>9 N. Hanson St. Easton, Md</u>		<b>DATE SIGNED</b> <u>2-7-56</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>2-9-56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Spring Hill</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Easton Md</u>	
<b>24. REC'D BY REGISTRAR</b> <u>2/8/56</u>		<b>REGISTRAR'S SIGNATURE</b> <u>N.A. Neerius</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Allen Elrod</u> <u>Easton</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED

*Robert*

*Wm*

AGE

*Robert*

*At the age of*

*7*

*April 10, 1920*

*Robert Campbell, Jr. A. J.*  
*Frederick County*

*Robert Campbell, Jr.*  
*Frederick County*

*Trans No. 1*

BUREAU V. S.

FEB 14 1921

RECEIVED

*Robert Campbell*

## 2180 CERTIFICATE OF DEATH

Reg. Dist. No. 290...

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Talbot</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Talbot</u>
CITY (If outside corporate limits, write RURAL OR TOWN) <u>40 Easton</u>	LENGTH OF STAY (in this place) <u>5 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Neavitt</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>80 Memorial Hosp.</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Estelle</u>		<u>Shores</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>July 11 - 1887</u>
9. AGE last birthday <u>68</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME: <u>Mr. Edwin T. Fisher</u>	
14. MOTHER'S MAIDEN NAME: <u>Frances Hill</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mr. Maurice Shores (Husband)</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>			<u>36 hrs.</u>
ANTECEDENT CAUSE (S) (B) <u>Diabetes Mellitus</u>			<u>5 yrs.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Hypertensive Cardiovascular Dis.</u>			<u>5 yrs.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>29 Jan.</u> , 1956, to <u>2 Feb.</u> , 1956, that I last saw the deceased alive on <u>2 Feb.</u> , 1956, and that death occurred at <u>10 P.</u> M, from the causes and on the date stated above.			
SIGNATURE <u>R. Lane Wrath</u>		M. D. <u>St. Michael's Md.</u> DATE SIGNED <u>2-7-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-4-56</u>	
NAME OF CEMETERY OR CREMATORY <u>Oliver</u>		LOCATION (City, town, or county) (State) <u>St. Michael's Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-3-56</u>		REGISTRAR'S SIGNATURE <u>H. H. Neer</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>Wm. Marshall</u>	

MARGIN RESERVED FOR BINDING

RECEIVED

FEB 14 1956

BUREAU V. S.



2181

## CERTIFICATE OF DEATH

Reg. Dist. No. 290...

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Talbot</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Caroline</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>40</u> TOWN <u>Easton</u>	LENGTH OF STAY (in this place) <u>3 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Preston</u> <u>05x-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>80</u> <u>Memorial Hospital</u>		STREET ADDRESS (If rural give location) <u>Y</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Thomas Foreman Smith</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Feb.</u> <u>17</u> , <u>1956</u>	
5. SEX: <u>m</u>	6. COLOR OR RACE: <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>August 9, 1886</u>
9. AGE last birthday <u>69</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY: <u>nm</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME: <u>George W Smith</u>	
14. MOTHER'S MAIDEN NAME: <u>Jane Robertson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>7</u>		17. INFORMANT & ADDRESS: <u>Mrs R. Paul Thomas (Sister)</u>	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
527.1 IMMEDIATE CAUSE		(A) <u>Emphysema</u>	
ANTECEDENT CAUSE (S)		DUE TO <u>Myocardial infarction</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) <u>Myocardial infarction</u>	
		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>2</u>	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from ..... , 19....., to ..... , 19....., that I last saw the deceased alive on ..... , 19....., and that death occurred at ..... M, from the causes and on the date stated above. SIGNATURE <u>W. H. Nevers</u> M. D. <u>Easton</u> DATE SIGNED <u>2-18-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Feb 20</u>	<u>Deer Creek Cemetery</u>	<u>Easton</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>2-18-56</u>	<u>W. H. Nevers</u>	<u>A. Angel Moore</u>	<u>Easton</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 27 1956

RECEIVED

## 2182 CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Talbot</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Caroline</i>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
40 TOWN <i>E. Aston</i>		10 days		TOWN <i>Greensboro</i> 058-2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Memorial Hospital</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: (Type or Print) <i>Charles Henry Sparks</i>				DEATH: 2 3 1956			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
M	White	Married	August 29, 1892	63 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<i>Steel Constructor</i>		<i>Iron Works</i>		<i>Maryland</i>		<i>U. S. A.</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>Mr. Henry Sparks</i>				<i>Sarah Anderson</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
				<i>Mrs. Grace Sparks (wife)</i>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) <i>Myocardial Infarct</i>							
ANTECEDENT CAUSE (S) DUE TO <i>Coronary thrombosis</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <i>smoking</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
2							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 24, 1956, to Feb. 3, 1956 that I last saw the deceased alive on Jan. 3, 1956, and that death occurred at 10:20 P.M. from the causes and on the date stated above.							
SIGNATURE <i>Paul H. Sparks</i>		M. D. <i>Carlton</i>		DATE SIGNED <i>Feb. 4, 1956</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Buried</i>		2/6/56		<i>Greensboro</i>		<i>Greensboro Md.</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
3-4-56		<i>N. A. Neer</i>		<i>J. E. Boulaes</i>		<i>Greensboro Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 14 1952

BUREAU V. S.

## 2183 CERTIFICATE OF DEATH

Reg. Dist. No. 290...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>TALBOT</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>TALBOT</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>40 EASTON</u>		LENGTH OF STAY (in this place) <u>28 DRS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>EASTON</u>		<u>40</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>80 EASTON Memorial</u>				STREET ADDRESS (If rural give location) <u>313 SOUTH Lane</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>William H. STATEN</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>2 14 1956</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>COLORED</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>	8. DATE OF BIRTH: <u>1/6/1872</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Labrer</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>	
13. FATHER'S NAME: <u>Henry STATEN</u>				14. MOTHER'S MAIDEN NAME: <u>LAROLINE LITSON</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Anno Leluan (daughter)</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>420.0 Uremia</u>						<u>7-10 dgs</u>	
ANTECEDENT CAUSE (B) <u>Cardiac Decompensation</u>						<u>2 wks</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Hypertensive Arteriosclerotic Heart Disease</u>						<u>20 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Osteoarthritis</u>						<u>25 yrs</u>	
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/2</u> , 19 <u>36</u> , to <u>2/14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/4</u> , 19 <u>56</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.							
SIGNATURE <u>James B. Blum</u>		M. D. <u>Preston M. G.</u>		DATE SIGNED <u>2/15/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/17/56</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant</u>		LOCATION (City, town, or county) (State) <u>Preston Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2/15/56</u>		REGISTRAR'S SIGNATURE <u>N. H. Neekes</u>		24. FUNERAL DIRECTOR <u>James B. Blum</u>		ADDRESS <u>Easton, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 23 1956

BUREAU V. S.



## 2184 CERTIFICATE OF DEATH

Reg. Dist. No. 290...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Talbot</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Talbot</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
40 TOWN <i>Easton</i>		14 days		TOWN <i>Easton</i>		40	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
80 <i>Memorial Hospital</i>				1			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<i>Nannie Irene Stevens</i>				2 11 1956			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>Female</i>	<i>W</i>	<i>Single</i>	<i>Jan. 21 1867</i>	<i>89</i> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country):	
<i>Retired</i>				<i>Teacher</i>		<i>Maryland</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>Nicholas Bourdeau Stevens</i>				<i>Marie Elizabeth Benson</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
						<i>Mrs Irene S. Hardin (Peterson)</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE				(A) <i>Cerebrovascular Thrombosis</i>			
ANTECEDENT CAUSE (S)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) <i>Arteriosclerosis - generalized</i>			
				DUE TO			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>June</i> , 19 <i>44</i> to <i>Feb. 4</i> , 19 <i>56</i> that I last saw the deceased alive on <i>Feb. 4</i> , 19 <i>56</i> , and that death occurred at <i>1:25 AM</i> , from the causes and on the date stated above.							
SIGNATURE		M. D.		ADDRESS		DATE SIGNED	
<i>M. V. Palmer</i>				<i>Easton, Md</i>		<i>2/17/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>2/13/56</i>		<i>Orford</i>		<i>Orford Talbot Md</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>2/12/56</i>		<i>N. A. Newries</i>		<i>M. E. Newries &amp; Son</i>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 6 1956

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02184

2192

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>TALBOT</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>TALBOT</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>TRAPPE</u>		<u>Entire life</u>		TOWN <u>TRAPPE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ELLEN</u> (Middle) <u>LEE</u> (Last) <u>SULLIVAN</u>				(Month) <u>FEB.</u> (Day) <u>21</u> (Year) <u>19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>FEMALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>APR. 4, 1914</u>	<u>41</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
<u>Housewife</u>				<u>MARYLAND</u>		<u>U.S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>OLIVER L. CORKRAN</u>				<u>NELLIE GRIFFITH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
		<u>None</u>		<u>MR DOUGLAS SULLIVAN-TRAPPE MD.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
592X IMMEDIATE CAUSE (A) <u>Uremia</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO <u>Chronic nephritis</u>						<u>6 mos.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)						<u>Years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hypertension</u>						<u>Years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-8-</u> , 19 <u>55</u> , to <u>2-21-</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-21-56</u> , 19 <u>56</u> , and that death occurred at <u>2:40 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Donald J. Bartley</u>				M.D. <u>9 N. Hanson St. Easton, Md.</u>		DATE SIGNED <u>2-21-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>SPRING HILL CEMETERY</u>		<u>EASTON TALBOT MD.</u>			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>2/22/56</u>		<u>N. S. Neenan</u>		<u>Maurice E. Newnam</u>		<u>Easton Md.</u>	

# 2192 CERTIFICATE OF DEATH

BALTIMORE STATE DEPARTMENT OF HEALTH-BALTIMORE 12

1. NAME OF DECEASED (Print or Write)

2. SEX

3. AGE (Years and Months)

4. RACE

5. PLACE OF BIRTH

6. DATE OF DEATH

7. TIME OF DEATH

8. PLACE OF DEATH

9. CAUSE OF DEATH (Print or Write)

BUREAU V. S.

FEB 27 1956

RECEIVED

## 2185 CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Talbot</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Talbot</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Easton</i>	LENGTH OF STAY (in this place) <i>2 da.</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>	<i>40</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Memoria Hospital</i>		STREET ADDRESS (If rural give location) <i>1</i>	
3. NAME OF DECEASED: (First) (Middle) (Last) <i>Baby Boy Thomas</i>		4. DATE (Month) (Day) (Year) OF DEATH: <i>2 9 1956</i>	
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <i>2-7-56</i>
9. AGE last birthday		IF UNDER 1 YEAR	IF UNDER 24 HRS.
		Months <i>2</i>	Days <i>2</i> Hours <i></i> Min. <i></i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <i>md.</i>
13. FATHER'S NAME: <i>William E. Thomas</i>		14. MOTHER'S MAIDEN NAME: <i>Adney Minster</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <i>Audrey Thomas (mother)</i>	
16. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <i>760.0</i>		(A) <i>Intracranial Hemorrhage</i>	
ANTECEDENT CAUSE (S)		(B) <i></i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C) <i></i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<i>2</i>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>2-7-</i> , 19 <i>56</i> , to <i>2-9-</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Feb. 9</i> , 19 <i>56</i> , and that death occurred at <i>8:30</i> A.M. from the causes and on the date stated above.			
SIGNATURE <i>Donald H. Bartley</i>		DATE SIGNED <i>2-9-56</i>	
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		DATE THEREOF <i>2/10/56</i>	
NAME OF CEMETERY OR CREMATORY <i>Memorial Hospital</i>		LOCATION (City, town, or county) (State) <i>Memorial Hospital</i>	
DATE REC'D BY LOCAL REGISTRAR <i>2/10/56</i>		REGISTRAR'S SIGNATURE <i>M. H. Neer</i>	
FUNERAL DIRECTOR <i>Memorial Hospital</i>		ADDRESS <i>Easton Md</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 23 1956

BUREAU V. S.



2193

02186

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. ....

## 1. PLACE OF DEATH:

COUNTY **TALBOT** MARYLAND  
 CITY (If outside corporate limits, write RURAL OR and give nearest town) **NR EASTON**  
 TOWN **NR EASTON** LENGTH OF STAY (In this place)

HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **MARYLAND** COUNTY **CAROLINE**  
 CITY (If outside corporate limits write RURAL and give nearest town) **FEDERALSBURG**  
 TOWN **FEDERALSBURG**

STREET ADDRESS (If rural, give location)

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

**JOHN****IRELAND****WELLS**

## 4. DATE OF DEATH

(Month)

(Day)

(Year)

**2****8****19 56**

## 5. SEX:

**male**

## 6. COLOR OR RACE:

**white**

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

**married**

## 8. DATE OF BIRTH:

**12/22/06**

## 9. AGE last birthday:

**49**

yrs.

## IF UNDER 1 YEAR IF UNDER 24 HRS.

Months

Days

Hours

Min.

## 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

**Truck Driver**

## 10b. KIND OF BUSINESS OR INDUSTRY:

## 11. BIRTHPLACE (State or foreign country):

**N. J.**

## 12. CITIZEN OF WHAT COUNTRY?

**U.S.**

## 13. FATHER'S NAME:

**John I. Wells**

## 14. MOTHER'S MAIDEN NAME:

**Nettie Bergman**

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

**Yes****✓****World War II**

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) **Carbon monoxide poisoning**

DUE TO

Antecedent cause(s)

Diseases or conditions, if any,  
 giving rise to the above cause  
 stating underlying cause last

(b) **sleeping in cab of parked tractor-trailer**

DUE TO

(c)

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDING OF OPERATION:

## 20. AUTOPSY?

Yes ☒ No ☐21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

## 21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY off Route 50

## 21c. (City or town)

**nr Easton**

## (County)

**Talbot**

## (State)

**Md**21d. TIME (Month) (Day) (Year) (Hour) OF INJURY **2 8 56 e 2AM**21e. INJURY OCCURRED While at / Not while at work ☒ at work ☐

## 21f. HOW DID INJURY OCCUR?

**parked to sleep-asphyxiated**

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

**Lewis M. Mott****Easton, Md. M. D.**

CHIEF MEDICAL EXAMINER ☐  
 DEPUTY MEDICAL EXAMINER ☒  
 ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED

**12-10-56**

## 23. BURIAL, CREMATION, REMOVAL (Specify):

**Burial**

## DATE THEREOF

**2/11/56**

## NAME OF CEMETERY OR CREMATORY

**East New Market**

## LOCATION (City, town, or county)

**East New Market, Md.**

(State)

## DATE REC'D BY LOCAL REG.

**2/9/56**

## REGISTRAR'S SIGNATURE

**N. H. Nevius**

## 24. FUNERAL DIRECTOR

**J. J. Frampton**

## ADDRESS

**Federalsburg Md.**

MARGIN RESERVED FOR BONDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Two for One: Film 92 2-15-56 et

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02187

2194

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>talbot</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Easton</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Easton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route 3, Box 128</u>				STREET ADDRESS (If rural give location) <u>Route 3 Box 128</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Hazel</u> (First) <u>Wilkins</u> (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>2</u> <u>14</u> <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>5/29/1893</u>	9. AGE last birthday <u>62</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Wilkins</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or <u>unk.</u> ) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-24-4232</u>		17. INFORMANT & ADDRESS <u>Mrs Fannie Wilkins</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
IMMEDIATE CAUSE (A) <u>Cerebral Vascular Hemorrhage</u>						<u>Instant.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardiovascular Disease</u>						<u>Yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Chronic Glomerulonephritis</u>						<u>Yrs.</u>	
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from <u>6/20</u>, 19<u>55</u>, to <u>2/14</u>, 19<u>56</u>, that I last saw the deceased alive on <u>2/13</u>, 19<u>56</u>, and that death occurred at <u>5 P.</u>M, from the causes and on the date stated above.</b>							
SIGNATURE <u>Shepherd</u> M.D.				ADDRESS (Street, city, town, state) <u>Easton</u>		DATE SIGNED <u>2/18/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/17/56</u>		NAME OF CEMETERY OR CREMATORY <u>Cordova Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cordova, Md</u>	
24. REC'D BY REGISTRAR DATE <u>FEB 27 1956</u>		REGISTRAR'S SIGNATURE <u>N. J. Newlin</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Dashiell</u>		ADDRESS <u>Easton, Md.</u>	

e.v.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

REG-0101-100

1. PLACE OF DEATH

MARYLAND

DATE

TIME

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

TIME OF BIRTH

AGE AT DEATH

SEX AT DEATH

RACE AT DEATH

EDUCATION AT DEATH

OCCUPATION AT DEATH

RELIGION AT DEATH

CAUSE OF DEATH AT DEATH

MANNER OF DEATH AT DEATH

PLACE OF BIRTH AT DEATH

DATE OF BIRTH AT DEATH

TIME OF BIRTH AT DEATH

BUREAU V. S.

FEB 27 1951

RECEIVED